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RUPTURED ECTOPIC PREGNANCY;  
LATE OPERATION; RECOVERY.

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## A REMARKABLE CASE OF RUPTURED ECTOPIC PREGNANCY ; LATE OPERATION ; RECOVERY.\*

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On account of the complications and the contingency successfully met, this case is presented as one of interest. She was a woman twenty-five years of age, mother of four children, the youngest two years old, and had had two abortions, the last three years since. The menstruation was normal; the last two months, however, it did not appear. For the past four weeks she had had some nausea, and occasional vomiting, with pains in the back and abdomen.

For the week preceding her admission to the hospital she had sharp pains in the lower part of the abdomen, and on the night before coming in they were accompanied by nausea, vomiting, and cold sweat. The following day there was dullness in the hypogastric region, tender on pressure; pulse 100, quite weak; temperature  $98.2^{\circ}$ . At intervals of a day or so the pains were repeated, with a gradual increase of dullness, until a prominence appeared in the hypogastric region, which was mistaken for a distended bladder. The temperature ranged from subnormal to a slight increase above normal, the circulation growing weaker and the surface paler. Such was the history prior to the time I first saw her.

On inspection, I found that the prominence in the hypogastric region had extended upward to within two inches of the umbilicus and laterally a little beyond the central portion of the inguinal region upon either side, which, taken in connection with the history and the character of the circulation, suggested ruptured ectopic pregnancy. Preparing to examine *per vaginam*, I was informed that she was menstruating; but feeling assured that it was a metrostaxis, and explaining the same to the attendants, I confirmed the diagnosis by outlining the lower portion of the immense clot in the abdominal cavity. I advised an immediate operation, but through some misunderstanding

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she was not placed in my charge for about forty hours, at which time the blood-clot had extended to a point two inches above the umbilicus, with a regular rounded outline, distending the abdomen fully as much as a six and a half months' pregnancy. The circulation was very weak, and the temperature below normal. By the time preparations were completed for the operation the outline of the mass of clots had changed, a projection or protuberance about the size of a No. 250 orange appearing on its margin in the left hypochondriac region.

The operation was done on the tenth day after the primary rupture. The incision passed through a gangrenous patch of peritonæum about two inches and a half in diameter, which could be easily removed by sponging. The omentum immediately beneath it and overlying a very firm portion of the clot was uninjured and not adherent to the abdominal wall, though firmly attached to the uterus, upper margins of the broad ligament, and brim of the pelvis. After releasing it both broad ligaments were clamped, as it was impossible to determine without loss of time which side the haemorrhage came from on account of the mass of adhesions and clots.

Above, the mass of clots was sacculated by agglutination of the intestines, except at the point described as a protuberance. There the gestation sac was found completely severed and lying loose in the left hypochondriac region.

After cleansing the cavity and separating the adhesions, a surface as large as my two hands upon the coils of small intestines was raw and bleeding. A spot about the extent of sixteen square inches on the descending colon was perfectly black, being in a very low state of vitality, and just below it was another place of equal size of a dark-green color, while in the pelvis no healthy peritonæum was left.

After liberating and tying off the appendages the clamps were removed. Upon the right side there was softening of the ligament, which, with the pressure of the clamp and tension of the ligatures, caused the broad ligament to slowly tear away from the uterus to a point below the internal os. This was a feature altogether unexpected, and the woman being in a precarious condition, having lost before the operation blood enough to destroy the life of two persons, made the situation rather serious.

The bleeding ligament was tied in two sections, but the margin of the uterus was so friable that ordinary measures of haemostasis were impracticable. I was therefore brought face to face with a hysterectomy in a woman whose pulse was 160 per minute and very feeble, even under vigorous stimulation. As ideal surgery is not always the

best surgery, the quickest and shortest way out of the difficulty was adopted. The uterus was drawn up out of the wound, encircled with an elastic ligature, transfixated with "skewer" pins, and cut off below the internal os (retraction of the bladder from the constant upward displacement enabling it) and anchored in the lower angle of the wound by a running silk suture, all in less than two minutes. At this juncture forty-eight ounces of salt solution were thrown in the median basilic vein before its effect became perceptible upon the pulse. The operation was then completed by thorough irrigation, gauze packing to keep intestines out of the raw pelvis, and a rubber drainage under the gangrenous peritonæum. She was kept upon the table and surrounded by artificial heat and stimulated until the pulse came down to 140, when she was transferred to the bed. Under active stimulation she made a good recovery. The stump came away in fourteen days and the wound healed without any evidence of weakness in the abdominal wall.

In the outset hysterectomy was not desirable, the uterus not being sufficiently diseased to require it. The appendages on both sides, however, were sacrificed, on account of the mutilation necessary to liberate them from the extensive adhesions.

As to the method of removing the uterus, it was not an ideal one, but the only one admissible under the circumstances. The time necessary to have done a complete hysterectomy or an intraperitoneal stump would have cost the patient her life; hence a life-saving method instead of an ideal or fancy operation was employed.





